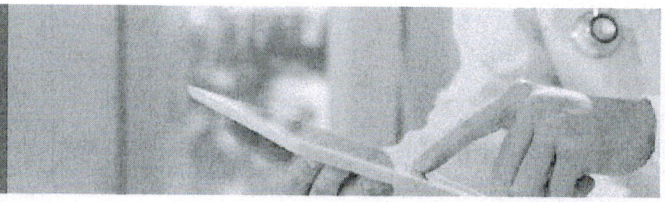
EXHIBIT “B”

Independence

Commercial
Medical Policy



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Medical Policy Bulletin

Title: **Treatment of Gender Dysphoria**

Policy #: **11.09.02h**

This policy is applicable to the Company's commercial products only. Policies that are applicable to the Company's Medicare Advantage products are accessible via a separate Medicare Advantage policy database.

The Company makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on contract, and individual member benefits must be verified. The Company determines medical necessity only if the benefit exists and no contract exclusions are applicable.

When services can be administered in various settings, the Company reserves the right to reimburse only those services that are furnished in the most appropriate and cost-effective setting that is appropriate to the member's medical needs and condition. This decision is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.

This Medical Policy Bulletin document describes the status of medical technology at the time the document was developed. Since that time, new technology may have emerged or new medical literature may have been published. This Medical Policy Bulletin will be reviewed regularly and be updated as scientific and medical literature becomes available. For more information on how Medical Policy Bulletins are developed, go to the About This Site section of this Medical Policy Web site.

Policy

Coverage is subject to the terms, conditions, and limitations of the member's contract. The Company reserves the right to reimburse only those services that are furnished in the most appropriate and cost-effective setting that is appropriate to the member's medical needs and condition.

MEDICALLY NECESSARY

PUBERTY-SUPPRESSING HORMONES
Puberty suppressing hormones (e.g., Supprelin LA® [histrelin acetate], Vantas® [histerlin acetate], Lupron Depot® [leuprolide acetate for depot suspension], Viadur® [leuprolide acetate implant], Eligard® [(leuprolide acetate for injectable suspension], Zoladex® [goserelin acetate implant], Trelstar® [triptorelin pamoate for injectable suspension]) are considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed), in accordance with criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5].*
- The individual has reached at least Tanner Stage 2 of development.
- Gender dysphoria emerged or worsened with the onset of puberty.

Note: Subject to the terms, conditions, and limitations of the member's contract, oral and self-administered hormones are not covered under the medical benefit.

CONTINUOUS HORMONE REPLACEMENT THERAPY
Continuous hormone replacement therapy (e.g., testosterone enanthate, testosterone pellet, estradiol valerate or medroxyprogesterone acetate) for the treatment of gender dysphoria is considered medically necessary and, therefore, covered when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria diagnosed in accordance with the criteria established in the

Diagnostic and Statistical Manual of Mental Disorders , Fifth edition [DSM-5].

Note: Subject to the terms, conditions, and limitations of the member's contract, oral and self-administered hormones are not covered under the medical benefit.

BILATERAL MASTECTOMY
Bilateral mastectomy is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5].*
- Bilateral mastectomy is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery.
    - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age.
- The individual, if required by the mental health professional provider, has regularly participated in psychotherapy throughout a real-life experience at a frequency determined jointly by the individual and the mental health professional provider.
- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

BREAST AUGMENTATION
Breast augmentation is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5].*
- Breast augmentation is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery.
    - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age.
- The individual, unless medically contraindicated, has used feminizing hormones continuously and responsibly (which may include screenings and follow-ups with the professional provider) for a 12-month period.
- The individual, if required by a mental health professional provider, has regularly participated in psychotherapy throughout the real-life experience at a frequency determined jointly by the individual and the mental health professional provider.
- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

GENITAL RECONSTRUCTIVE SURGERY
Genital reconstructive surgery is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5].*
- Genital reconstructive surgery is recommended by two different qualified professional providers who have consistently monitored the individual up to the time of surgery.
    - If two mental health professional providers are working jointly with the individual, both mental health professional providers must sign one letter of recommendation and/or chart documentation to the professional provider performing the genital surgery.
    - If two mental health professional providers are working independently with the individual, each mental health professional provider must write a separate letter of recommendation and/or chart documentation to the professional provider performing the genital surgery.
        - The letters and/or chart documentation must discuss the same topics in agreement with one another.
        - At least one of the letters and/or chart documentation must be an extensive report; the second letter may be a briefer summary.
- The individual is at least 18 years of age.
- The individual, unless medically contraindicated, has used cross-gender hormone therapy continuously and responsibly (which may include screenings and follow-ups with the professional provider) for a 12-month period.
- The individual has demonstrated successful, continuous full-time, real-life experience living in a gender role that is congruent with an individual's gender identity (i.e., the act of fully adopting a new or evolving gender role or gender presentation in everyday life) for a 12-month period.
- The individual, if required by the mental health professional provider, has regularly participated in psychotherapy throughout the real-life experience at a frequency determined jointly by the individual and the mental health professional provider.
- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

When all of the above criteria are met, the following genital reconstructive surgeries are covered for individuals assigned male gender at birth, who do not identify as such:

- Orchiectomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty

When all of the above criteria are met, the following genital reconstructive surgeries are covered for individuals assigned female gender at birth, who do not identify as such:

- Hysterectomy
- Salpingo-oophorectomy

- Vaginectomy
- Metoidioplasty
- Phalloplasty
- Urethroplasty
- Scrotoplasty
- Testicular prostheses implantation

PENILE PROSTHESIS
Surgical implantation of a penile prosthesis in a neo-phallus (phalloplasty) is considered medically necessary and, therefore, covered, when the following criteria are met:

- The last genital reconstructive surgical procedure has healed.
- There is tactile sensitivity of the neo-phallus (phalloplasty).

MEDICALLY NECESSARY GENDER-SPECIFIC SERVICES

Gender-specific services may be medically necessary for transgender individuals as appropriate to their anatomy (e.g., mammograms, prostate cancer screening).

NOT MEDICALLY NECESSARY

Gender-reversal surgery post-operatively is considered not medically necessary and, therefore, not covered.

POTENTIALLY COSMETIC

The following procedures/therapies may be performed in combination with other surgeries for the treatment of gender dysphoria and are considered cosmetic or potentially cosmetic services, unless medical necessity demonstrating a functional impairment can be identified. Services that are cosmetic, following medical necessity review, are a benefit contract exclusion for all products of the Company and, therefore, not eligible for reimbursement consideration. This list is subject to change; refer to Company policy that addresses cosmetic services.

- Abdominoplasty
- Blepharoplasty
- Body contouring procedures (e.g., liposuction, lipectomy)
- Botox injections
- Calf implantation
- Cervicoplasty/platysmaplasty
- Chin augmentation (genioplasty, mentoplasty)
- Collagen injections
- Dermabrasions/chemical peels
- Excision of redundant skin
- Facial masculinizing/feminizing surgeries (e.g., facial bone reduction)
- Facial prosthesis (e.g. nasal, orbital)
- Forehead reduction
- Gluteal augmentation (e.g., silicone implants, fat transfer, fat grafting)
- Hair reconstruction (e.g. hair removal/electrolysis, hair transplantation, wigs)
- Injectable dermal fillers (e.g., Sculptra, Radiesse)
- Lip reduction/enhancement
- Orthognathic procedures
- Otoplasty
- Pectoral implantation
- Rhinoplasty
- Rhytidectomy
- Septoplasty
- Tattooing (non therapeutic)
- Trachea shave/reduction thyroid chondroplasty
- Voice therapy
- Voice modification surgery (i.e., laryngoplasty, cricothyroid approximation)

Specific Company medical policies may exist for medical necessity criteria for non-cosmetic uses of a potentially cosmetic procedure. Please refer to such individual policies for criteria that address cosmetic services.

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

The Company may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Company upon request. Failure to produce the requested information may result in a denial for the service.

Guidelines

LETTERS OF RECOMMENDATION

The mental health professional provider's recommendation letter for surgery should include all of the following:

The individual's general identifying characteristics
- The initial and evolving gender, sexual, and other psychiatric diagnoses
- The duration of their professional relationship, including the type of psychotherapy or evaluation that the individual underwent
- The eligibility criteria that have been met and the mental health professional provider's rationale for hormone therapy or surgery
- The degree to which the individual has followed the eligibility criteria to date and the likelihood of future compliance
- Whether the author of the letter is part of a gender team
- The sender welcomes a phone call to verify the fact that the mental health professional provider actually wrote the letter as described in this document

When two letters of recommendation are required and the first letter is from an individual with a master's degree, the second letter should be from a psychiatrist or a PhD-level clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions.

BENEFIT APPLICATION

Services that are cosmetic are a benefit contract exclusion for all products of the Company. Therefore, they are not eligible for reimbursement consideration.

BILLING GUIDELINES

Current Procedural Terminology (CPT) codes 55970 Intersex surgery; male to female or CPT 55980 Intersex surgery; female to male, are considered global procedure codes. These codes include distinct surgical procedures. Do not report individual procedure codes representing each component of a global procedure code.

CPT 55970 (Intersex surgery; male to female), includes the following procedures:

- Orchiectomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty

CPT 55980 (Intersex surgery; female to male), includes the following procedures:

- Vaginectomy
- Metoidioplasty
- Phalloplasty
- Urethroplasty
- Scrotoplasty
- Testicular prostheses implantation

Description

GENDER DYSPHORIA

Gender dysphoria, previously known as gender identity disorder, is the distress that may accompany the incongruence between one's experienced/expressed gender and one's assigned gender (gender at birth or natal gender).

DIAGNOSIS

CHILDREN
The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* diagnostic criteria for gender dysphoria in children is marked incongruence between one's experienced and/or expressed gender and the assigned gender, of at least six months' duration, as manifested by a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) AND at least five of the following:

- In males (assigned gender), a strong preference to cross-dressing or simulating female attire; or in females (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toy, games, or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- In males (assigned gender), a strong rejection of typical masculine toys, games, and activities, and a strong avoidance of rough-and-tumble play; or in females (assigned gender), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- Clinically significant distress or impairment in social, school, or other important areas of functioning

ADOLESCENTS AND ADULTS
The *DSM-5* diagnostic criteria for gender dysphoria in adolescents and adults is marked incongruence between one's experienced and or expressed gender and assigned gender, of at least six months duration as manifested by a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) AND at least two or more of the following indicators:

- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender

- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- Clinically significant distress or impairment in social, occupational, or other important areas of functioning.

TREATMENT

Distress between one's assigned gender and experienced gender may be alleviated via a variety of therapeutic options that may vary between individuals. The process of changing one's gender is not one procedure but a complex process that may involve multiple stages (e.g., behavioral health interventions, experience living in the desired gender role, hormone therapy, and surgical options).

Behavioral health interventions may include integration of trans or cross-gender feeling and expressions into the gender role, which may involve living in another gender role, consistent with one's gender identity.

Hormone therapy may include the use of masculinizing or feminizing hormones (e.g., testosterone enanthate, testosterone pellet, estradiol valerate, or medroxyprogesterone acetate) in adolescents and adults, or the use of puberty-suppressing hormones (e.g., Supprelin LA® [histrelin acetate], Vantas® [histerlin acetate], Lupron Depot® [leuprolide acetate for depot suspension], Viadur® [leuprolide acetate implant], Eligard® [(leuprolide acetate for injectable suspension], Zoladex® [goserelin acetate implant], Trelstar® [triptorelin pamoate for injectable suspension]) in children.

Individuals with gender dysphoria may undergo surgery to change chest structure, genitalia, and/or other characteristics. Typically, surgery is considered an irreversible physical intervention.

GENDER-SPECIFIC SERVICES

Professional organizations such as the American Cancer Society (ACS), the American College of Obstetricians and Gynecologists (ACOG), and the US Preventive Services Task Force (USPSTF) provide recommended screening guidelines to facilitate clinical decision-making by professional providers. Somescreening protocols are sex/gender-specific based on assumptions about the anatomy for a particular gender. There is difficulty in recommending sex/gender-specific screenings (e.g., breast, prostate) for transgender individuals because of their physiologic changes. For example, transmen who have not undergone a mastectomy may have the same risks for breast cancer as a natal female. In transwomen, if the prostate is not removed as part of genital surgery, individuals may be at the same risk for developing prostate cancer as a natal male. Therefore, gender-specific services (e.g., mammograms, prostate screenings) may be indicated based on the individual's natal gender.

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Coding

Inclusion of a code in this table does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

The codes listed below are updated on a regular basis, in accordance with nationally accepted coding guidelines. Therefore, this policy applies to any and all future applicable coding changes, revisions, or updates.

In order to ensure optimal reimbursement, all health care services, devices, and pharmaceuticals should be reported using the billing codes and modifiers that most accurately represent the services rendered, unless otherwise directed by the Company.

The Coding Table lists any CPT, ICD-9, ICD-10, and HCPCS billing codes related only to the specific policy in which they appear.

CPT Procedure Code Number(s)

11960, 11970, 11971, 11980, 11981, 19303, 19324, 19325, 19340, 19342, 19350, 19357, 19380, 53430, 54125, 54400, 54401, 54405, 54520, 54660, 54690, 55175, 55180, 55970, 55980, 56805, 57106, 57110, 57291, 57292, 57335, 58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58720

Professional and outpatient claims with a *date of service* on or before September 30, 2015, must be billed using ICD-9 codes.
Professional and outpatient claims with a *date of service* on or after October 1, 2015, must be billed using ICD-10 codes.

Facility/Institutional inpatient claims with a *date of discharge* on or before September 30, 2015, must be billed with ICD-9 codes.
Facility/Institutional inpatient claims with a *date of discharge* on or after October 1, 2015, must be billed with ICD-10 codes.

ICD - 10 Procedure Code Number(s)

N/A

Professional and outpatient claims with a *date of service* on or before September 30, 2015, must be billed using ICD-9 codes.
Professional and outpatient claims with a *date of service* on or after October 1, 2015, must be billed using ICD-10 codes.

Facility/Institutional inpatient claims with a *date of discharge* on or before September 30, 2015, must be billed with ICD-9 codes.
Facility/Institutional inpatient claims with a *date of discharge* on or after October 1, 2015, must be billed with ICD-10 codes.

ICD -10 Diagnosis Code Number(s)

F64.0 Transsexualism

F64.1 Dual role transvestism

F64.2 Gender identity disorder of childhood

F64.8 Other gender identity disorders

F64.9 Gender identity disorder, unspecified

Z87.890 Personal history of sex reassignment

HCPCS Level II Code Number(s)

C1789 Prosthesis, breast (implantable)

C1813 Prosthesis, penile, inflatable

C2622 Prosthesis, penile, noninflatable

J1050 Injection, medroxyprogesterone acetate, 1 mg

J1071 Injection, testosterone cypionate, 1 mg

J1380 Injection, estradiol valerate, up to 10 mg

J1950 Injection, leuprolide acetate (for depot suspension), per 3.75 mg

J3121 Injection, testosterone enanthate, 1 mg

J3315 Injection, triptorelin pamoate, 3.75 mg

J3316 Injection, triptorelin, extended-release, 3.75 mg

J9202 Goserelin acetate implant, per 3.6 mg

J9217 Leuprolide acetate (for depot suspension), 7.5 mg

J9219 Leuprolide acetate implant, 65 mg

J9225 Histrelin implant (Vantas), 50 mg

J9226 Histrelin implant (Supprelin LA), 50 mg

L8600 Implantable breast prosthesis, silicone or equal

S0189 Testosterone pellet, 75 mg

Revenue Code Number(s)

N/A

Cross References

Policy: 07.10.06h: Assisted Reproductive Technology for Infertility and Oocyte Cryopreservation

Policy: 08.00.26w: Botulinum Toxin Agents

Policy: 11.00.02f: Treatment of Medical and Surgical Complications

Policy: 11.01.01j: Otoplasty or Non-Surgical External Ear Molding

Policy: 11.05.02i: Blepharoplasty, Repair of Blepharoptosis, Repair of Brow Ptosis, and Canthoplasty/Canthopexy

Policy: 11.06.09d: Labiaplasty

Policy: 11.08.01g: Hair Transplants and Cranial Prostheses (Wigs)

Policy: 11.08.02h: Reduction Mammoplasty

Policy: 11.08.03j: Lipectomy and Liposuction

Policy: 11.08.05g: Application and Removal of Tattoos

Policy: 11.08.06j: Panniculectomy, Abdominoplasty, and Other Excisions of Redundant Skin

Policy: 11.08.08g: Chemical Peels

Policy: 11.08.13g: Rhytidectomy and/or Cervicoplasty With or Without Liposuction and/or Platysmaplasty

Policy: 11.08.15x: Reconstructive Breast Surgery

Policy: 11.14.01g: Mentoplasty or Genioplasty

Policy: 11.16.01h: Septoplasty, Rhinoplasty, and Septorhinoplasty

Policy: 12.01.03: Cosmetic Procedures

Policy History

11.09.02h:

01/01/2020	This version of the policy will become effective 01/01/2020. This policy has been identified for the CPT code update, effective 01/01/2020. The following code has been **DELETED** from the policy: 19304

11.09.02g:

04/15/2019	This version of the policy will become effective 04/15/2019. The following criteria has been **DELETED** from the policy: Under continuous hormone replacement therapy and puberty-suppressing hormones medically necessary policy statements • Recommended by a qualified professional provider who has consistently assessed the individual • One referral letter and/or chart documentation for hormone therapy is required from a qualified professional provider.

	• If the individual has significant medical or mental health concerns, they are reasonably well controlled.

11.09.02f:

01/01/2019	This policy has been identified for the HCPCS code update, effective 01/01/2019. The following HCPCS code has been **added** to this policy: J3316. The following HCPCS code has been **deleted** from this policy: C9016.

11.09.02e:

11/21/2018	This policy has been reviewed and reissued to communicate the Company's continuing position on Treatment of Gender Dysphoria.
01/01/2018	This policy has been identified for the HCPCS code update, effective 01/01/2018. The following HCPCS code has been **added** to this policy: C9016 Injection, triptorelin extended release, 3.75 mg

11.09.02d:

11/03/2017	This version of the policy will become effective 11/03/2017. The intent of this policy remains unchanged, but the policy has been updated to further clarify the following: • Transgender language to include all gender nonconforming individuals • Potentially cosmetic or cosmetic procedures/therapies

Effective 10/05/2017 this policy has been updated to the new policy template format.

Version Effective Date: 01/01/2020
Version Issued Date: 12/31/2019
Version Reissued Date: N/A